FOR BHF USE

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019976

Facility Name: The H & J Vonderlieth Living Center

Address: 1120 North Topper Drive (Number) Mount Pulaski (City) 62548 (Zip Code)

County: Logan

Telephone Number: (217)792-3218 **Fax #** (217)792-3210

HFS ID Number: 37-0967671001

Date of Initial License for Current Owners: 10/21/1973

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501c3		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Cindy Russell
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Michael Coffman, Partner
(Firm Name & Address) Spencer & Coffman, CPA, LLP, 3110 Kandy Lane Decatur IL 62526
(Telephone) (217)875-5080 Fax # (217)875-1163

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		363		363	8
9	SNF/PED					9
10	ICF	9,572	16,066		25,638	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,572	16,429		26,001	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.15%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/21/1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 90 and days of care provided 1,920

Medicare Intermediary Mutual of Omaha Medicare

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/06 Fiscal Year: 12/31/06

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 **Report Period Beginning:** 1/1/2006 **Ending:** 12/31/2006

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	235,634	18,595	4,333	258,562	(37,701)	220,861		220,861			1
2	Food Purchase		205,461		205,461	(31,710)	173,751	(1,650)	172,101			2
3	Housekeeping	77,418	28,211		105,629		105,629		105,629			3
4	Laundry	31,538	4,001		35,539		35,539		35,539			4
5	Heat and Other Utilities			122,565	122,565		122,565	(6,749)	115,816			5
6	Maintenance	72,504	20,896	38,800	132,200		132,200	3,274	135,474			6
7	Other (specify):* See Page 24			3,134	3,134		3,134		3,134			7
8	**TOTAL General Services**	417,094	277,164	168,832	863,090	(69,411)	793,679	(5,125)	788,554			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,487,684	112,663	3,515	1,603,862		1,603,862		1,603,862			10
10a	Therapy	44,428		2,410	46,838		46,838		46,838			10a
11	Activities	29,594	3,383	645	33,622		33,622		33,622			11
12	Social Services	35,002		3,537	38,539		38,539		38,539			12
13	CNA Training											13
14	Program Transportation			1,626	1,626		1,626		1,626			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,596,708	116,046	11,733	1,724,487		1,724,487		1,724,487			16
	C. General Administration											
17	Administrative	79,631		194	79,825		79,825		79,825			17
18	Directors Fees											18
19	Professional Services			19,167	19,167		19,167		19,167			19
20	Dues, Fees, Subscriptions & Promotions			16,422	16,422		16,422	(603)	15,819			20
21	Clerical & General Office Expenses	71,574	11,350	15,627	98,551		98,551		98,551			21
22	Employee Benefits & Payroll Taxes			378,285	378,285	69,411	447,696		447,696			22
23	Inservice Training & Education			875	875		875		875			23
24	Travel and Seminar			364	364		364		364			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			101,468	101,468		101,468		101,468			26
27	Other (specify):* See Page 24			10,671	10,671		10,671	(8,697)	1,974			27
28	**TOTAL General Administration**	151,205	11,350	543,073	705,628	69,411	775,039	(9,300)	765,739			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,165,007	404,560	723,638	3,293,205		3,293,205	(14,425)	3,278,780			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The H & J Vonderlieth Living Center #0019976 **Report Period Beginning:** 1/1/2006 **Ending:** 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			206,665	206,665	(57,866)	148,799	7,225	156,024			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			206,665	206,665	(57,866)	148,799	7,225	156,024			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			11,476	11,476		11,476		11,476			38
39	Ancillary Service Centers		68,853	186,545	255,398		255,398		255,398			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):* See Page 24			27,554	27,554	57,866	85,420	(85,420)				43
44	**TOTAL Special Cost Centers**		68,853	274,850	343,703	57,866	401,569	(85,420)	316,149			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,165,007	473,413	1,205,153	3,843,573		3,843,573	(92,620)	3,750,953			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,650)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,749)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,225	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(25)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,697)	27		24
25	Fund Raising, Advertising and Promotional	(578)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,474)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (10,474)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

The H & J Vonderlieth Living Center

ID# 0019976

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartment Expenses	$ (85,420)	43	1
2	Write off deferred maintenance items	3,274	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(82,146)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 **Report Period Beginning:** 1/1/2006 **Ending:** 12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,650)	0	0	0	0	0	0	0	0	0	0	(1,650)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,749)	0	0	0	0	0	0	0	0	0	0	(6,749)	5
6	Maintenance	3,274	0	0	0	0	0	0	0	0	0	0	3,274	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,125)	0	0	0	0	0	0	0	0	0	0	(5,125)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(603)	0	0	0	0	0	0	0	0	0	0	(603)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(8,697)	0	0	0	0	0	0	0	0	0	0	(8,697)	27
28	**TOTAL General Administration**	(9,300)	0	0	0	0	0	0	0	0	0	0	(9,300)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,425)	0	0	0	0	0	0	0	0	0	0	(14,425)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number The H & J Vonderlieth Living Center **#** 0019976 **Report Period Beginning:** 1/1/2006 **Ending:** 12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	7,225	0	0	0	0	0	0	0	0	0	0	7,225	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	7,225	0	0	0	0	0	0	0	0	0	0	7,225	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(85,420)	0	0	0	0	0	0	0	0	0	0	(85,420)	43
44	**TOTAL Special Cost Centers**	(85,420)	0	0	0	0	0	0	0	0	0	0	(85,420)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(92,620)	0	0	0	0	0	0	0	0	0	0	(92,620)	45

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number The H & J Vonderlieth Living Center **#** 0019976 **Report Period Beginning:** 1/1/2006 **Ending:** 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2001	8
	2002	9
	2003	10
	2004	11
	2005	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2005	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The H & J Vonderlieth Living Center COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0019976

CONTACT PERSON REGARDING THIS REPORT Cindy Russell

TELEPHONE (217) 792-3218 FAX #: (217) 792-3210

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A Tax Exempt		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,140 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

25 apartments owned by the corporation

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Buildings and Grounds	2,163,000	1971	$ 55,924	1
2					2
3	TOTALS	2,163,000		$ 55,924	3

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1973	1973	$ 1,172,276	$ 29,307	35	$ 33,494	$ 4,187	$ 1,065,697	4
5	30		1977	1977	441,636	11,041	35	12,618	1,577	365,134	5
6											6
7											7
8											8
	Improvement Type**										
9	Heating System			1979	3,848		20			3,848	9
10	Conversion			1979	11,345	344	33	344		9,455	10
11	Medicine Room			1981	474		20			474	11
12	Sidewalks			1981	1,209		20			1,209	12
13	Shower room			1982	1,175	34	35	34		830	13
14	Blacktopping			1983	5,095		20			5,095	14
15	Landscapring			1984	1,000		10			1,000	15
16	Remodeling			1984	3,117		20			3,117	16
17	Parking Lot			1985	36,890		15			36,890	17
18	Fire Hydrant			1985	1,308		15			1,308	18
19	Building Improvement			1985	5,201	173	30	173		3,697	19
20	Energy Management System			1985	9,381		20			9,381	20
21	Blacktopping			1986	3,885	118	20	118		3,885	21
22	Shrubs			1986	583		10			583	22
23	Sewer Lift Station			1986	40,129	1,848	20	1,848		40,129	23
24	Sewer Lift Station			1987	15,420	771	20	771		15,356	24
25	Windows improvements			1988	4,721		5			4,721	25
26	Fan			1988	1,743		5			1,743	26
27	Office Remodeling			1988	1,580		15			1,580	27
28	Patio Door			1990	985		15			985	28
29	Trees			1990	700		10			700	29
30	Air Conditioner			1991	53,731	1,493	15	1,493		53,731	30
31	Buiilding Improvements (ceilings, lift station, temperature controls)			1991	16,133		10			16,133	31
32	Building Improvements (kitchen floor, sprinklers, fire doors)			1991	43,767	1,067	15	1,067		43,767	32
33	Fire Alarm Panels			1992	4,622	308	15	308		4,569	33
34	Water Softener			1992	7,887		10			7,887	34
35	Walk In Cooler			1992	12,469	623	20	623		8,774	35
36	Door Monitor System			1992	1,700		10			1,700	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	30 Heating Units	1992	$ 9,810	$ 491	20	$ 491	$	$ 7,242	37
38	Blacktopping	1992	2,859		10			2,859	38
39	Library Paneling	1993	3,900	195	20	195		2,649	39
40	Convection units	1993	3,270	164	20	164		2,241	40
41	Computer rooms-drywall	1994	2,244		10			2,244	41
42	Pump	1994	3,439		10			3,439	42
43	Roof	1995	324,374	12,975	25	12,975		154,545	43
44	Room size heater	1995	1,604		10			1,604	44
45	Heating System Units	1995	9,772		20			9,772	45
46	Garage Doors	1996	1,550	90	10	90		1,550	46
47	80 gallon water heater	1996	7,611	508	10	508		7,611	47
48	Exhaust Fan	1997	1,691	169	10	169		1,521	48
49	Therapy. Activity, administration offices, and additional storage	1998	796,976	22,905	35	22,905		195,704	49
50	Additional finish costs (line 49 above)	1998	4,715		35			4,715	50
51	Dampers and motor actuator	1998	3,293	165	20	165		1,471	51
52	Chiller	1998	14,853	743	20	743		6,625	52
53	Moveable wall	1998	9,830	393	25	393		3,242	53
54	Boiler programmer	1998	2,570	129	20	129		1,150	54
55	80 gallon water heater	1998	5,287	529	10	529		4,629	55
56	Chain link fence	1999	1,019	68	15	68		510	56
57	Lowered "one head"	2000	2,087	209	10	209		1,341	57
58	8 steel universal access doors 24"x24"	2000	437	44	10	44		282	58
59	11 smoke & fire dampers	2000	21,450	2,145	10	2,145		13,228	59
60	Card zone expander installed	2000	3,185	319	10	319		1,967	60
61	Floor tile for center corridor & dining room	2000	6,290	419	15	419		2,549	61
62	Blacktopping drive (from def maint per IDPH review 2000 report)	2000	7,309		5	1,461	1,461	7,309	62
63	Boiler	2001	64,480	3,224	20	3,224		16,662	63
64	4" wall base in corridors & dining room	2001	19,200	1,280	15	1,280		6,507	64
65	12 time delayed locks on outside doors	2002	23,618	2,362	10	2,362		9,650	65
66	Boiler room hollow steel door	2002	1,233	35	35	35		169	66
67	Garage	2002	71,872	2,053	35	2,053		8,366	67
68	Driveway Entrance Sign	2003	1,967	131	15	131		437	68
69	West chain link fence 800'	2003	6,800	677	15	677		1,636	69
70	TOTAL (lines 4 thru 69)		$ 3,344,605	$ 99,549		$ 106,774	$ 7,225	$ 2,198,804	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,344,605	$ 99,549		$ 106,774	$ 7,225	$ 2,198,804	1
2	Compressor for chiller	2003	7,126	713	10	713		2,317	2
3	Sidewalks	2004	10,150	677	15	677		1,636	3
4	Asphalt near dumpster	2004	648	130	5	130		271	4
5	Asphalt and sealcoat	2004	13,303	2,661	5	2,661		5,765	5
6	Front entry doors	2004	5,405	270	20	270		783	6
7	Breaker box	2004	581	39	15	39		94	7
8	Recepticles in dining room	2004	1,950	78	25	78		189	8
9	Ceiling tile	2004	3,318	166	20	166		470	9
10	16 red Led exit signs	2005	886	59	15	59		108	10
11	Door and wall protection coverings	2005	3,993	266	15	266		310	11
12	Tile - south hall	2005	8,600	430	20	430		538	12
13	Vinyl - 4 south rooms	2005	7,245	362	20	362		422	13
14	Carpet - living room and front entry	2005	9,300	930	10	930		1,008	14
15	Gazebo roof	2005	3,312	166	20	166		263	15
16	Kitchen air handler	2005	1,449	145	10	145		266	16
17	Fan coil installed	2005	1,996	200	10	200		350	17
18	HVAC units	2005	6,612	661	10	661		1,047	18
19	Parking lot lights	2005	3,295	220	15	220		238	19
20	Water chiller	2006	47,600	1,666	25	1,666		1,666	20
21	Laundry room A/C	2006	1,848	46	20	46		46	21
22	Sewerage lift station	2006	14,645	122	25	122		122	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,497,867	$ 109,556		$ 116,781	$ 7,225	$ 2,216,713	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 388,711	$ 28,404	$ 28,404	$	5-15 yrs	$ 139,563	71
72	Current Year Purchases	67,205	2,856	2,856		5-25 yrs	2,856	72
73	Fully Depreciated Assets	375,096	3,201	3,201		5-15 yrs	375,096	73
74								74
75	TOTALS	$ 831,012	$ 34,461	$ 34,461	$		$ 517,515	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient transport	2000 Chev Supreme Bus	1999	$ 43,000	$	$	$	6	$ 43,000	76
77	Patient transport	2002 Olds Silhouette	2001	28,690	4,782	4,782		6	25,105	77
78										78
79										79
80	TOTALS			$ 71,690	$ 4,782	$ 4,782	$		$ 68,105	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,456,493	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 148,799	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 156,024	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,225	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,802,333	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment land improvements	$ 89,458	$ 6,985	$ 74,256	86
87	Apartments	1,480,167	47,273	810,796	87
88	Portraits	6,000			88
89	Equipment	36,661	3,608	23,597	89
90					90
91	TOTALS	$ 1,612,286	$ 57,866	$ 908,649	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2007	$
13.	/2008	$
14.	/2009	$

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	1,724	$ 77,606	$	1,724	$ 77,606	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		246	14,015		246	14,015	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,754	86,119		1,754	86,119	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts		1,920	68,853		1,920	68,853	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab Services	39(3)				8,805			8,805	13
14	TOTAL			$	5,644	$ 255,398	$	5,644	$ 255,398	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The H & J Vonderlieth Living Center **#** 0019976 **Report Period Beginning:** 1/1/2006 **Ending:** 12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2006 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 470,208	$	1
2	Cash-Patient Deposits	4,892		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	297,743		3
4	Supply Inventory (priced at fifo cost)	23,587		4
5	Short-Term Investments	4,144,855		5
6	Prepaid Insurance	18,221		6
7	Other Prepaid Expenses	486		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	1,510		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,961,502	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	55,924		13
14	Buildings, at Historical Cost	5,039,142		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	973,713		16
17	Accumulated Depreciation (book methods)	(3,703,757)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,365,022	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,326,524	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 56,734	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	189,466		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Patient Care Prepayments	4,992		36
37	Employee Benefits Withheld	127		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 251,364	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Apartment Residents Deposits	1,185,187		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,185,187	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,436,551	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,889,973	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,326,524	$	48

***(See instructions.)**

Facility Name & ID Number The H & J Vonderlieth Living Center **#** 0019976 **Report Period Beginning:** 1/1/2006 **Ending:** 12/31/2006

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,382,572	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,382,572	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	507,401	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 507,401	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,889,973	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,327,345	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,327,345	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	323,194	24
25	Interest and Other Investment Income***	648,895	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 972,089	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Apartment income	51,540	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,540	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,350,974	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	863,090	31
32	Health Care	1,724,487	32
33	General Administration	705,628	33
	B. Capital Expense		
34	Ownership	206,665	34
	C. Ancillary Expense		
35	Special Cost Centers	294,428	35
36	Provider Participation Fee	49,275	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,843,573	40
41	**Income before Income Taxes (line 30 minus line 40)****	507,401	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 507,401	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,082	$ 66,207	$ 31.80	1
2	Assistant Director of Nursing	1,920	2,081	60,920	29.27	2
3	Registered Nurses	4,351	4,493	99,493	22.14	3
4	Licensed Practical Nurses	24,964	26,983	560,681	20.78	4
5	CNAs & Orderlies	56,734	60,686	608,084	10.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,263	3,650	47,947	13.14	8
9	Activity Director	2,825	3,215	27,402	8.52	9
10	Activity Assistants	315	322	2,192	6.81	10
11	Social Service Workers	1,948	2,054	35,002	17.04	11
12	Dietician					12
13	Food Service Supervisor	1,852	2,055	27,975	13.61	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,871	22,785	207,659	9.11	15
16	Dishwashers					16
17	Maintenance Workers	3,595	3,936	72,504	18.42	17
18	Housekeepers	9,626	10,246	92,941	9.07	18
19	Laundry	5,429	5,954	31,537	5.30	19
20	Administrator	2,024	2,177	79,632	36.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,716	5,188	71,574	13.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,975	5,554	73,257	13.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	151,336	163,461	$ 2,165,007 *	$ 13.24	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	100	$ 4,328	1(3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	600	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	66	3,537	12(3)	45
46	Other(specify)				46
47		44	2,410	100(3)	47
48					48
49	TOTAL (lines 35 - 48)	222	$ 10,875		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Russell	Administrator	0	$ 79,631
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,631

B. Administrative - Other

Description	Amount
Flower expense	$ 194
TOTAL (agree to Schedule V, line 17, col. 3)	$ 194
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Helen Meagher CPA	Audit, Cost Rpt, 990	$ 8,000
Duane Morris LLP	Legal	4,999
RSM McGladery Inc	Accounting	1,210
Altschuler Melvoin Glasser	Medicare cost report	4,958
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 19,167

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,871
Unemployment Compensation Insurance	7,910
FICA Taxes	158,434
Employee Health Insurance	104,172
Employee Meals	69,411
Illinois Municipal Retirement Fund (IMRF)*	
Employee background check	592
Employee physicals	1,340
Other employee benefits	3,966
TOTAL (agree to Schedule V, line 22, col.8)	$ 447,696

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	8,771
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Facility Advertising	603
Subscriptions	305
Fees	100
Life services network dues	4,653
Less: Public Relations Expense	( )
Non-allowable advertising	(603)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,819

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	364
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 364

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	Repair chiller	8/97	$ 1,917	5	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$
2	Repair walk in freezer	9/99	1,746	5	349	234	0	0	0	0	0	0	
3	Vinyl Wall Coverings	7/99	14,358	5	2,872	1,434	0	0	0	0	0	0	
4	Chiller compressor replac	6/00	5,789	5	1,158	1,158	482	0	0	0	0	0	
5	Repair chiller	7/02	2,975	5	595	595	595	595	347	0	0	0	
6	Freezer repairs	6/02	2,369	5	474	474	474	474	236	0	0	0	
7	Generator circuit load dat	4/03	2,354	5	353	471	471	471	471	117	0	0	
8	Collapsed sewer repair	9/04	5,307	5	0	354	1,061	1,062	1,061	1,062	707	0	
9	Boiler burner repaired	4/05	1,637	5	0	0	246	327	327	327	327	83	
10	Replaced hot gas valve	9/05	1,724	5	0	0	115	345	345	345	345	229	
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 40,176		$ 5,801	$ 4,720	$ 3,444	$ 3,274	$ 2,787	$ 1,851	$ 1,379	$ 312	$

Facility Name & ID Number The H & J Vonderlieth Living Center # 0019976 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $4653**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,568** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **49,275**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **69,411** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **4,833**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Spencer & Coffman CPA LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.